SERFF Tracking Number:	*PHYS-125741006*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*39696*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002 Dread Disease*
Product Name:	*A176-1T*		
Project Name/Number:	*A176-1T/A176-1T*		

Filing at a Glance

Company: Physicians Mutual Insurance Company

Product Name: A176-1T	SERFF Tr Num: PHYS-125741006	State: ArkansasLH
TOI: H07I Individual Health - Specified Disease - Limited Benefit	SERFF Status: Closed	State Tr Num: 39696
Sub-TOI: H07I.002 Dread Disease	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Kathryn Gurnett	Disposition Date: 07/22/2008
	Date Submitted: 07/22/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: A176-1T	Status of Filing in Domicile: Authorized
Project Number: A176-1T	Date Approved in Domicile: 07/18/2008
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/22/2008	
State Status Changed: 07/22/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

NAIC – 80578 FEIN – 47-0270450

Physicians Mutual Insurance Company

A176AR-1T – Telesales Application for Specified Disease

SERFF Tracking Number:	*PHYS-125741006*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*39696*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002 Dread Disease*
Product Name:	*A176-1T*		
Project Name/Number:	*A176-1T/A176-1T*		

The above captioned form is enclosed for your review and approval. This form is new and does not replace any currently approved forms. To the best of my knowledge this form complies with all state laws and regulations.

The A176AR-1T application will be used by our Direct Response distribution channel for the P176AR which was approved by your department on December 21, 2006, or any similar approved forms in the future.

The Flesch score for this application will always be above the minimum required by your law when scored with the base policy. This form was approved by our state of domicile, Nebraska on July 18, 2008.

We reserve the right to alter the format of the form(s) submitted herein without refiling due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. Any changes to wording or content would be filed prior to approval.

Company and Contact

Filing Contact Information

Kathryn Gurnett, Policy Approval & Compliance Coordinator
2600 Dodge Street
Omaha, NE 68131

katie.gurnett@physiciansmutual.com
(402) 633-1188 [Phone]
(402) 633-1096[FAX]

Filing Company Information

Physicians Mutual Insurance Company
2600 Dodge Street
Omaha, NE 68131
(402) 633-1188 ext. [Phone]

CoCode: 80578
Group Code: 367
Group Name:
FEIN Number: 47-0270450

State of Domicile: Nebraska
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	

SERFF Tracking Number:	*PHYS-125741006*	*State:*	*Arkansas*
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Company Tracking Number:			
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Product Name:	*A176-1T*		
Project Name/Number:	*A176-1T/A176-1T*		

Per Company: No

SERFF Tracking Number:	*PHYS-125741006*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*39696*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002 Dread Disease*
Product Name:	*A176-1T*		
Project Name/Number:	*A176-1T/A176-1T*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Physicians Mutual Insurance Company	$20.00	07/22/2008	21528818

SERFF Tracking Number:	*PHYS-125741006*	*State:*	*Arkansas*
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Product Name:	*A176-1T*		
Project Name/Number:	*A176-1T/A176-1T*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/22/2008	07/22/2008

SERFF Tracking Number:	*PHYS-125741006*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*39696*
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Product Name:	*A176-1T*		
Project Name/Number:	*A176-1T/A176-1T*		

Disposition

Disposition Date: 07/22/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PHYS-125741006*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*39696*
Company Tracking Number:			
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Product Name:	*A176-1T*		
Project Name/Number:	*A176-1T/A176-1T*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	SPECIFIED DISEASE APPLICATION	Approved-Closed	Yes

SERFF Tracking Number:	*PHYS-125741006*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*39696*
Company Tracking Number:			
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Product Name:	*A176-1T*		
Project Name/Number:	*A176-1T/A176-1T*		

Form Schedule

Lead Form Number: A176AR-1T

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	A176AR-1T	Application/ Enrollment Form	SPECIFIED DISEASE APPLICATION	Initial		40	A176AR-1T.pdf

Physicians Mutual Insurance Company
2600 Dodge Street, Omaha, Nebraska 68131

SECTION A **APPLICATION FOR SPECIFIED DISEASE POLICY [P176]**

GENERAL INFORMATION

(Include all family members proposed for coverage, if additional space is needed please use form AM5-1296.)

Applicant's Name ________ (First M.I. Last) Birthdate ________ (Mo. Day Year) Age ________ ☐ Female ☐ Male

Mailing Address ________ (Street City State Zip) Height ________ Weight ________

Home Phone # (Area Code) ( ) Work Phone # (Area Code) ( ) Cell Phone # (optional) (Area Code) ( )

Applicant's SSN ________ E-Mail Address: (optional)

Are all persons proposed for coverage U.S. citizens? . . . . . ☐ Yes ☐ No

If no, have they resided in the United States for more than 2 years and are permanent residents? . . . . . ☐ Yes ☐ No

(If yes, please provide a copy of their green card.)

Is this a Child Only application? ☐ Yes ☐ No If Yes, Policyowner Name ________

Policyowner Address ________ Policyowner Social Security # ________

Relationship to Applicant ☐ Parent ☐ Legal Guardian Policyowner Date of Birth ________

Spouse's Name *(if applicable)* ________ (First M.I. Last) Birthdate ________ (Mo. Day Year) Age ________ ☐ Female ☐ Male

Spouse's SSN ________ Height ________ Weight ________

Dependent's Name *(if applicable)* ________ (First M.I. Last) Birthdate ________ (Mo. Day Year) Age ________ ☐ Female ☐ Male

Dependent's SSN ________ Currently attending college, vocational or technical school? ☐ Yes ☐ No

Educational institution and phone number *(if applicable)* ________ # of credit hrs. ________

Dependent's Name *(if applicable)* ________ (First M.I. Last) Birthdate ________ (Mo. Day Year) Age ________ ☐ Female ☐ Male

Dependent's SSN ________ Currently attending college, vocational or technical school? ☐ Yes ☐ No

Educational institution and phone number *(if applicable)* ________ # of credit hrs. ________

Dependent's Name *(if applicable)* ________ (First M.I. Last) Birthdate ________ (Mo. Day Year) Age ________ ☐ Female ☐ Male

Dependent's SSN ________ Currently attending college, vocational or technical school? ☐ Yes ☐ No

Educational institution and phone number *(if applicable)* ________ # of credit hrs. ________

SECTION B

COVERAGE SPECIFICATIONS

Policy Coverage

Choose Your Level of Benefits (Check One) ☐ 1 Unit ☐ 2 Units

Optional Riders (Children are not eligible for Rider B276)

☐ B276, First Diagnosis Critical Illness Benefit Rider (Select Benefit Level)
☐ $5,000 Maximum ☐ $10,000 Maximum ☐ $20,000 Maximum

☐ B277, First Diagnosis Internal Cancer Benefit Rider (Select Benefit Level)
☐ $2,500 Benefit ☐ $5,000 Benefit ☐ $10,000 Benefit

Will this coverage replace any existing health insurance currently in force? ☐ Yes ☐ No

Company ________ Type of Coverage ________

Termination Date of Coverage ________

SECTION C HEALTH STATEMENT

1) Has anyone proposed for coverage ever had any symptoms of, had any diagnosis of, received treatment for, or consulted with a medical practitioner concerning any form of cancer (excluding non-melanoma skin cancer), melanoma, leukemia, Hodgkin's Disease, pre-malignant lesions, carcinoma in-situ, Acquired Immune Deficiency Syndrome (AIDS), positive HIV or AIDS Related Complex (ARC)? ☐ Yes ☐ No If "Yes", identify name(s) of person(s):

2) Within the last 3 years, has anyone proposed for coverage had any symptoms of, had any diagnosis of, received treatment for, or consulted with a medical practitioner concerning non-melanoma skin cancer? ☐ Yes ☐ No

If "Yes", identify name(s) of person(s):

Any persons named in (1) or (2) above will not be covered under the policy and benefit riders.

3) Within the last 12 months, has anyone proposed for coverage had, or been advised by a medical professional to have, any examinations, surgery, or other medical tests to confirm, exclude, or screen for the presence of cancer (including melanoma and other skin cancers), leukemia, Hodgkin's Disease, pre-malignant lesions, carcinoma in-situ, AIDS, HIV, or any immune deficiency disorder, which have not yet been completed, or for which test results were abnormal or are still pending? ☐ Yes ☐ No

If "Yes", identify name(s) of person(s):

Any persons named in (3) above will not be covered under the policy and benefit riders, but may reapply once diagnostic procedures and results are complete.

First Diagnosis Critical Illness Benefit Rider (Ask only if adding Rider B276. Children are not eligible.)

4) Has anyone proposed for coverage ever had any symptoms of, had any diagnosis of, received treatment for, or consulted with a medical practitioner concerning congestive heart failure, valvular heart disease, angina, coronary heart disease, heart rhythm disorder, aneurysm, stroke, cerebral vascular accident or disease, transient ischemic attack (TIA), carotid artery disease, or diabetes? ☐ Yes ☐ No If "Yes", identify name(s) of person(s):

Any persons named in (4) above will not be covered under the optional First Diagnosis Critical Illness Benefit Rider.

Payment Method Options (check one)

☐ Automatic Bank Withdrawal (monthly mode only) ☐ Credit Card MC\VISA (monthly mode only) ☐ Direct Bill

Payment Mode Options (Check one)

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

/ /		$	$
Date of Application	Requested Effective Date	Premium Collected	Modal Premium

APPLICANT STATEMENT

I represent that my answers and statements in this application are true and complete to the best of my knowledge and belief and I understand they are material to issuance of this Policy. I agree that the Company is not bound by any statement made to the agent unless written on this Application. I understand that: (1) no insurance will be effective on the Requested Effective Date unless this Application is approved, the Policy issued, and the first full premium has been paid, and no change has occurred in the health of any person to be insured at the time of the Company's approval of the application; (2) any information misrepresented or not disclosed by me in this Application may result in the denial of claims, the addition of an exclusionary rider, additional premium, or voiding of the Policy; (3) no benefit is payable for cancer or any other covered condition that occurs or is diagnosed within the first 30 days after the effective date of a covered person's coverage; (4) no cancer screening benefits are payable during the first 30 days after the effective date of a covered person's coverage; and (5) no benefits are payable for loss due to cancer or any other covered condition that occurs or is diagnosed within two years after the effective date of a covered person's coverage if such loss is due to a pre-existing condition. Pre-existing conditions include symptoms or conditions that became evident or were treated within one year immediately preceding the effective date of a covered person's coverage.

I represent that the Applicant's signature below is the original, personal signature of the Applicant. **The Applicant must sign personally. Signatures under power of attorney will not be accepted.** *This representation does not apply to a Child Only Application (when a parent or legal guardian signs the Application on behalf of a child Applicant).*

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Agent

Signature of Applicant
(For Child Only Application: Signature of Parent/Legal Guardian)

Date Application Completed

Mo. Day Year

SERFF Tracking Number:	*PHYS-125741006*	*State:*	*Arkansas*
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Rate Information

Rate data does NOT apply to filing.

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Product Name:	*A176-1T*		
Project Name/Number:	*A176-1T/A176-1T*		

Supporting Document Schedules

		Review Status:	
Satisfied -Name:	Certification/Notice	Approved-Closed	07/22/2008

Comments:

Attachments:

Ar reg 19 cert.pdf

READCERT AR.pdf

		Review Status:	
Satisfied -Name:	Application	Approved-Closed	07/22/2008

Comments:

See Form Schedule for application

		Review Status:	
Bypassed -Name:	Health - Actuarial Justification	Approved-Closed	07/22/2008
Bypass Reason:	There are no rates associated with this filing.		

Comments:

		Review Status:	
Bypassed -Name:	Outline of Coverage	Approved-Closed	07/22/2008
Bypass Reason:	This is an application only filing. There are no changes to the previously approved outline of coverage.		

Comments:

CERTIFICATION

RE: A176AR-1T

This is to certify that the above captioned filing complies with Arkansas Regulation 19 and all other applicable requirements of the Arkansas Insurance Department.

Date: July 22, 2008

Shawn Pollock
Vice President
Government and Industry

PHYSICIANS MUTUAL INSURANCE COMPANY

OMAHA, NEBRASKA

Certification of Flesch

These form(s) have the following Flesch Readability Score:

Form	Flesch Score
A176AR-1T	40*

*When scored with the base policy, this form will always be the minimum required Flesch score.

Vice President
Physicians Mutual Insurance Company

July 21, 2008
Date